Mismanaged Care?

By Dennis Heffley and Anasua Bhattacharya

The American health care system has slogged its way through an alphabet soup of insurance acronyms—HMOs, IPAs, PPOs, and on down the line. More recently, it's become stylish to lump all but the most traditional insurance plans under the umbrella of "managed care organizations" or (jumping right back into the soup) "MCOs." But just what has managed care really delivered? Has it been the lid on the health care spending pot...or a fire beneath the cauldron? Perhaps both, but the record is poor, and it's time for some creative approaches to health insurance.

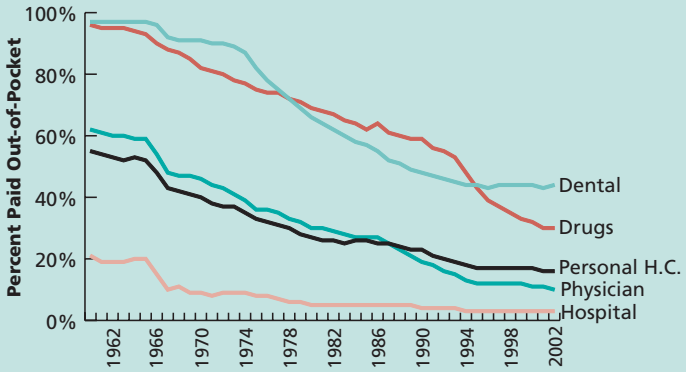
Features of Early HMOs

HMOs have grown over time. A few plans date back to the 1920s or 30s, but enrollment prior to 1970 was negligible. Spurred by rising health care costs, advocates persuaded Congress to pass the 1973 HMO Act. The Act provided some seed money for new HMOs, but more importantly it required large employers to offer an HMO insurance option to their workers if a "federally qualified" HMO served the employment area. Yet even federal inducements did not immediately boost enrollments.

Ultimately, what attracted people to HMOs was a different product: an insurance package that touted the merits of prevention and expanded access to care by covering services that traditional insurers had excluded—routine physician visits, dental care, prescriptions, vision services, and so on. HMOs also popularized fixed-dollar "copayments" in place of traditional "coinsurance," in which patients pay a percentage of the full price of care.

As HMOs attracted more members, traditional insurance plans adopted many of the same features. Not surprisingly, this "coverage competition" altered both the structure of insurance and the extent to which consumers were insulated from the direct cost of care. The line graph below shows how the average coinsurance rates (fraction paid out-of-pocket) have changed over time for personal health care spending and some of its components. These changes reflect a dramatic shift in health care financing, away from direct payments toward third-party payments by private insurers and government.

Consumers' Falling Share of Health Care Payments: Average Coinsurance Rates (1960-2002)



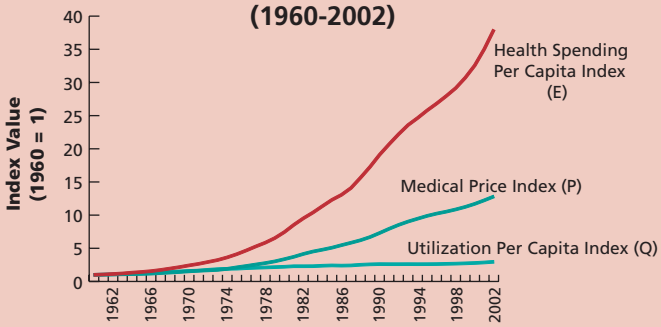
Source:. *The Connecticut Economy*, based on data from National Health Expenditure Accounts, Centers for Medicare & Medicaid Services (CMS).

Guess Who Pays

We shouldn't kid ourselves into thinking that, because we now pay a smaller share out-of-pocket, someone else is paying for health care. Besides copays, most workers also pay a portion of health insurance premiums. Less apparent, but no less significant, workers also forego higher wages to have the employer pay the rest of the premium. (This arrangement suits both parties because wages are taxed but employer premium payments are not.) Our taxes also support the public programs, Medicaid and Medicare. Bottom line: we paid then, we pay now...just differently, and considerably more.

The decline in coinsurance rates over time does indeed matter. Economic theory says that a lower average coinsurance rate will increase demand, causing price, quantity, and total payments for care to rise. That's precisely what has happened over time. The next line graph shows three indices for personal health care in the U.S., 1960-2002. Each index—price, quantity per capita, and per capita spending (from all sources)—is normalized to 1.0 for the base year (1960), helping us to see the relative rates of growth in the three measures. At any point in time, the index of expenditure per capita (E) equals the product of the price (P) and quantity (Q) indices.

Watch Those P's and Q's...and E's: Indices of Medical Prices, Utilization, and Per Capita Health Spending (1960-2002)



Source: *The Connecticut Economy*, from CMS and the Bureau of Labor Statistics data.

Note that price (the medical CPI) and quantity (personal health care spending per capita divided by the medical CPI) grew at similar rates from 1960 to 1973: 4.89% and 4.35%, respectively. But following implementation of the HMO Act, prices began to escalate sharply, rising by 7.13% per year from 1973 to 2002, while the average rate of growth in the quantity index fell to 1.62% per year. Consistent with the observed changes in the insurance structure, increased coverage and fixed copayments put upward pressure on gross prices, in turn prompting utilization controls by managed care plans. Empirical studies also confirm that managed care has controlled utilization more effectively than it has prices or expenditures.

Interestingly, though less apparent from the graph, the average rates of growth in per capita health care spending before and after 1973 are quite similar (9.45% and 8.86%), suggesting that the net effect of the "managed care revolution" has been a change in the *mix* of spending increases: larger *price* increases and smaller increases in *quantity*—not a very favorable outcome for consumers, especially the uninsured, who bear the full brunt of higher health care prices, forego care, or rely on "free" care from hospital emergency rooms.

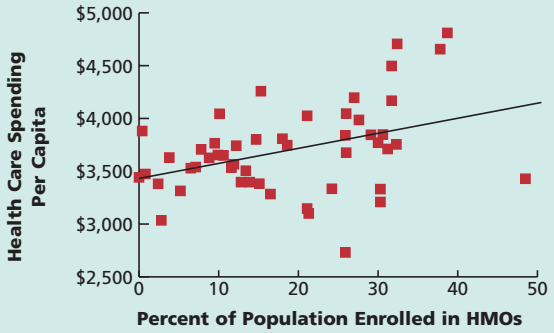
Note, however, that the medical price index may not fully reflect changes in the *quality* of health care. If quality has improved, higher prices could overstate the burden on consumers, although frequent complaints about the system suggest that less technical attributes of health care—timeliness, conve-

nience, reliability—may have deteriorated, partially offsetting any "better technology" bias.

Cross-Sectional Data

States differ in the degree to which HMOs have penetrated the health insurance market. The scatter diagram shows, for each state, the HMO penetration rate and the associated level of personal health care spending per capita in 1998. If HMOs effectively control spending, we might expect a negative relationship in the scatter, but the opposite holds. This could mean several things: (1) HMOs do little to contain spending, and may even increase it, as suggested by U.S. time-series data; (2) HMOs, seen as a cost-containment device, have found it easier to expand in high-spending states; (3) both of the above occur, but the inflationary effect of HMOs dominates; or (4) HMO penetration rates and per capita health spending appear positively linked only because of some other variable that is related to both. In any event, the evidence that HMOs effectively control health care prices or spending is mixed at best.

Do HMOs Limit Health Care Spending?



Source: *The Connecticut Economy*, from 1998 CMS data and the *Statistical Abstract of the United States*.

"We Have Met the Problem...Us"

The title of our piece does little to mend the "whipping boy" image of managed care. But, in truth, we've all had a hand in shaping the current system. The HMO concept, with its purported emphasis on preventive care and better coordination of services, appealed to many consumers. But the wholesale expansion of coverage, including more discretionary services, and the dilution of incentives for consumers to monitor their use of care and the prices charged to insurers, unleashed rapid inflation across many health care markets. And traditional insurers, bolstered by the tax exemption of employer-paid premiums, quickly followed suit. It's tempting to blame special-interest legislation for the tax exemptions, the inducements to managed care, and other policies that enabled this dramatic restructuring of the health care finance system. But few consumers, employers, health care providers, or insurers were lobbying hard against such provisions. And that's still true.

Faced with rising medical prices, people want more insurance, not less, even though more insurance will boost prices. Firms want to preserve the special tax treatment of health insurance premium payments, especially with these costs rising. And nearly every provider wants her particular type of care to be more fully covered, something that larger insurers often facilitate via their influence on state mandated coverages. Unfortunately, all of these wants and actions produce costlier health care and, it seems, more complaints about the system. Not a pretty picture. But maybe it's time to find solutions rather than culprits.

What's the Answer?

That old chestnut, the "fallacy of composition"—the notion that what works for one may not work for all—is precisely the problem with comprehensive health insurance. Individually, having more of it looks good. Unfortunately, as coverage expands, it inflates health care prices, prompting larger employee contributions, lower wages, and efforts to limit access to care, thereby eroding much of the personal benefit we expected. To break this cycle of collective frustration, any real cure for the health sector's ailments needs to do several things.

- **Restore economic incentives.** Well-insured consumers lose the incentive to monitor prices, so providers feel little need to make the information available. Prices clearly do matter to uninsured consumers—witness the Internet or cross-border drug purchases by many seniors. Yet, citing concerns about the safety of (U.S. produced) drugs bought from Canadian suppliers, the federal government outlaws the purchase of drugs at lower prices. Similarly, the newly minted Medicare drug plan requires authorities to pay list prices for U.S. drugs, prohibiting them from seeking volume discounts on taxpayers' behalf. Such quantity discounts are precisely how Canadian provincial governments buy U.S. drugs at lower prices, yet Medicare is forbidden to bargain similarly...by an act of Congress. Much could be done to increase transparency and restore price discipline in health care markets by moving away from copayments and back toward coinsurance, requiring all health care providers to clearly post prices, and removing bargaining restrictions.
- **Encourage better health.** A growing body of research suggests that more healthful lifestyles would lower the high costs of chronic disease. Obesity, smoking, excessive alcohol or drug use, and inactivity all contribute to these costs. Coupled with sensible preventive screening, changes in personal habits can reduce the need for medical intervention and prolonged drug therapy. Managed care may have done little to improve health habits, but this does not mean that insurance cannot play a constructive role.
- **Be creative**. For 25 years, Mendocino County (CA) schools have offered an innovative insurance plan that rewards healthier behavior and prudent use of care. The employer sets aside a target amount to pay for an initial amount of health care spending for each worker. Insurance kicks in after the target amount is exceeded, thereby preserving full coverage. But those who keep their annual charges below the target by staying healthy, using care more wisely, or seeking better prices, are rewarded by having the unused portion credited to their retirement plans.

By all accounts, both the employer and employees strongly endorse the plan, and initial concerns that workers would forego care, but later incur even higher costs, seem to have been unfounded. Most insurers dislike the plan, because the high-deductible policy used to supplement the self-insurance pool brings in lower premiums than a normal policy. In principle, though, even insurers could profit if the lower premiums are accompanied by even larger reductions in claims. The Mendocino Plan is simple but powerful: relatively full coverage is preserved, but consumers have a positive incentive to improve their lifestyles, monitor their own use of services, and care about the prices.

Carrots and Sticks

Like so many other issues, health care has become a political football for those who occupy the opposite end zones. Practical answers lie in sensible, "midfield" plans that balance the financial protection of insurance with the need for patients to be good consumers. The latter can be accomplished by penalties, but perhaps even more effectively by rewards. So far, we've mostly used sticks.

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